Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: ADVANCED PRACTICE ON BEHALF OF ST. LUKES BAPTIST HOSPITAL 17101 PRESTON ROAD SUITE 180-S DALLAS TX 75248	MFDR Tracking #: M4-09-7418-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE COMPANY Rep Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier, Texas Mutual Insurance, has denied reimbursement at the contracted state fee guideline. We have appealed to the Workers' Compensation Carrier, requesting reconsideration of denial and citing the hospital fee guideline published by the Department of Workers Compensation (DWC) which states, as of March 1, 2008, ***when requesting separate reimbursement for implantables*** *the reimbursement calculation shall be the Medicare facility-specific amount multiplied by 108% plus implants reimbursed at cost + 10% not to exceed $2,000.00*. We respectfully submit that…claim meets the reimbursement criteria and consequently, since we are requesting separate reimbursement for implantables, should be paid at 108% of the Medicare facility specific rate for DRG 470 plus implantables…We are requesting separate reimbursement for implantables, in additiona [sic] to the Medicare facility specific reimbursement amount multiplied by 108%."

Principle Documentation:

1. DWC 60 package
2. Hospital Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $2,509.73

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "It is Texas Mutual's position that the payment made is in accordance with the Inpatient Hospital Facility Fee Guideline (Rule 134.404 (f)(1)(A)(B)(g)(1); therefore, no further payment is due for the inpatient treatment rendered from 7/28/08 – 8/42008 [sic]…Review of claim…reflects the billing was received on 8/12/2008; no where does the facility include any information requesting separate reimbursement for implantable…therefore, this carrier calculated the reimbursement with the appropriate higher multiplier of 143%. The requestor's payment is based on DRG 470 multiplied by 143%...The requestor did not request separate reimbursement for implants with its billing; therefore, the Medicare facility reimbursement amount plus any applicable outlier payment is multiplied by 143%...It is Texas Mutual's position that payment is consistent with Rule 134.404 Hospital Facility Fee Guidelines for Inpatient Services; therefore, no further payment is due."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
07/28/2008 through 08/04/2008	**Inpatient Hospital Services**	$12,021.09 (DRG 470) +$0.00 (Outlier Amount) = $12,021.09 (IPPS) X 143% = $17,190.16 (MAR) minus $17,320.57 (Total paid by Respondent) = $0.00 due	$2,509.73	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.404, titled ***Hospital Facility Fee Guideline – Inpatient,*** effective for medical services provided in an inpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital inpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 09/24/2008
   - "CAC-W1 — Workers Compensation State Fee Schedule Adjustment.
   - CAC-97 — The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217 — The value of this procedure is included in the value of another procedure performed on this date.
   - 468 — Reimbursement is based on the Medical Hospital Inpatient Prospective Payment System methodology
   - ***Reimbursement made in accordance with Rule 13.4404(F)(1). Separate reimbursement for implantables was not requested in accordance with Rule 134.404(G)."

   Explanation of benefits with the listed date of audit 03/12/2009
   - "CAC-W1 — Workers Compensation State Fee Schedule Adjustment.
   - CAC-W4 — No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC-97 — The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217 — The value of this procedure is included in the value of another procedure performed on this date.
   - 468 — Reimbursement is based on the Medical Hospital Inpatient Prospective Payment System methodology.
   - 891 — The Insurance Company is reducing or denying payment after reconsideration.
   - ***Reimbursement made in accordance with Rule 13.4404(F)(1). Separate reimbursement for implantables was not requested in accordance with Rule 134.404(G)."
2. Rule 134.404 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. Pursuant to Rule §134.404(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.
4. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No contract exists;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables WAS NOT requested by the requestor with the billing.
5. Consequently, reimbursement will be calculated in accordance with Rule §134.404 (f)(1)(A) a follows:

   DRG 470 Medicare Facility Specific Amount including Outlier Payment Amount is X 143% = Total Allowance of $17,190.16 - Amount Paid by Respondent $17,320.57 = Additional Amount Due to Requestor of $0.00.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.404
28 TAC Rule §133.305
28 TAC Rule §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, §413.031, the Division has determined that the Requestor is entitled to $0.00 additional reimbursement.

		1/26/2010
Authorized Signature	Medical Fee Dispute Resolution Auditor	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.